

MINUTES OF MEETING OF
AMBULATORY SURGICAL SERVICES TECHNICAL ADVISORY COMMITTEE
Department of Community Health, Division of Health Planning
2 Peachtree Street, DHR Board Room, 29th Floor
Atlanta, Georgia 30303-3159

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Tuesday, May 6, 2003
1:30 am – 3:30 pm

William “Buck” Baker, Jr., M.D., Chair, Presiding

MEMBERS PRESENT

Tary Brown
W. Clay Campbell
Billy Carr
Kevin Chilvers
Kathy Floyd
J. Keener Lynn
Wallace McLeod, MD
William T. Richardson, FACHE
Raymer Sale, Jr.
William Silver, MD
Stephanie Simmons
David Tatum
Carol Zafiratos

GUESTS PRESENT

Jennifer Bach, Gill/Balsano Consulting
Todd Bacon, Northeast Georgia Health System
Armando Basarratte, Parker, Hudson, Rainer & Dobbs
Bill Calhoun, Langley & Lee
Gayle Evans, Continuum Healthcare Consulting
Wytaria Henley, Children’s Healthcare of Atlanta
Doug Holbrook, St. Joseph’s Hospital
Everette B. Jenkins, Strategic Health Concepts, Inc.
Ed Lovern, Piedmont Medical Center
S. Poneo, Phears & Maldovan
Kevin Rowley, St. Francis Hospital
Temple Sellers, Georgia Hospital Association
Helen Sloat, Nelson Mullins
Monty Veazey, Georgia Alliance of Community Hospitals
Deborah Winegard, Medical Association of Georgia

MEMBERS ABSENT

Michael Alexander
Sylvia Caley, RN, JD
Daniel DeLoach, MD
Mark M. Mullin

STAFF PRESENT

Valerie Hepburn
Marsha Hopkins, Esq.
Jamillah McDaniel
Clyde Reese, III, Esq.
Rhathelia Stroud, Esq.
Stephanie Taylor

WELCOME, INTRODUCTIONS AND COMMITTEE CHARGE

The first meeting of the Ambulatory Surgical Services Technical Advisory Committee (TAC) convened at 1:30 pm. Dr. Baker called on members to introduce themselves. He then reviewed the charge of the committee noting that the current state health component plan and rules governing the need for and operation of ambulatory surgery services were adopted in 1998. The guidelines address multi-specialty and limited-purpose freestanding ambulatory surgery. The vast majority of physician owned, single purpose surgical centers are exempt from the guidelines by law. Since the inception of the current component plan, concern has been raised about the need methodology, the planning areas, adverse impact on other providers, and the scope of the plan. DCH Board Members and a wide range of stakeholders have suggested that the plan needs to be reviewed and updated. The deliberations and decisions of the TAC would result in two work products:

- A recommended set of guidelines and a component plan to address ambulatory surgery services within the context of the current law.
- Proposed rules for consideration by the Board of Community Health.

The goal is to produce recommendations to be presented to the November meeting of the Health Strategies Council.

OVERVIEW OF THE CURRENT REGULATORY FRAMEWORK

Dr. Baker called on Clyde Reese, General Counsel for the Department of Community Health, to provide an overview of the current regulatory framework. Mr. Reese thanked members for their participation on the TAC and their leadership on this issue. He said that there are three categories of ambulatory surgery facilities, namely multi-specialty ambulatory surgery centers which require the issuance of a Certificate of Need (CON); physician-owned single-specialty office-based ambulatory surgical facilities which are statutorily exempt from Certificate of Need process but require the issuance of a Letter of Nonreviewability (LNR) and limited purpose ambulatory surgery centers. Some of the limited purpose ambulatory surgery centers meet all of the criteria of physician-owned single-specialty centers with the exception of exceeding the capital threshold. Mr. Reese emphasized that while there is great statewide interest in the LNR process, this committee cannot make changes to the LNR process since this regulatory process is set forth in state law and is outside of the purview of this TAC.

Mr. Reese further noted that the Department included an Exception to Need standard in the current rules to allow some flexibility in the review process. Under this rule, applicants could submit an application when no numerical need exists. The burden of proof is placed on the applicant to address how the establishment of the service that is being proposed will impact cost, quality or access to ambulatory surgery services.

Mr. Reese said that the Department would like the TAC's guidance on the following issues:

- What is a single specialty? The committee acknowledged that just because there is board certification in a particular specialty doesn't mean that it is a single specialty. The committee was encouraged to develop a list of all single specialties.

- How should physician-owned single specialty ambulatory surgery centers, which exceed the threshold, be treated? These centers essentially meet the criteria to be issued a LNR however they trigger the capital threshold and have to be reviewed under the Department's General Consideration provisions. The committee should determine whether these facilities should just have to address the General Considerations or if they should be required to meet the service-specific ambulatory surgery rules.

Mr. Reese indicated that the Department would not issue an LNR to a facility offering "general surgery" since clinicians operating in these facilities can perform a wide range of surgical procedures. The Department considers general surgery as a multispecialty.

Questions were asked about whether LNRs are site-specific. Mr. Reese indicated that a new LNR would be required should the office be move to a new location. The same is true of a relocating facility. A new application would be required.

OVERVIEW OF CURRENT COMPONENT PLAN

Valerie Hepburn indicated to TAC members that while there may be some area of the Department's rules or process that they would be unable to directly impact due to statutory limitations, that TAC members should feel comfortable including general recommendations for consideration by the Health Strategies Council and the Board of Community Health. These recommendations could be included in the revised Ambulatory Surgical Services Component Plan. She explained the components of the current Ambulatory Surgical Services Plan including the following:

NEED METHODOLOGY: The current need methodology is determined through the application of a numerical need method and an assessment of the aggregate utilization rate of existing services. It has several components including the determination of the number of dedicated ambulatory surgery rooms and the allocation of shared rooms in hospitals. The number of operating rooms that is needed is based on 1,000 patients per room (250 days/year by 5 patients/day at 80% utilization). She indicated that when the plan and rules were developed in 1998, the Division moved away from counting the number of procedures to examining the number of visits (patients). She indicated that there are advantages and disadvantages to this change. On one hand, there is a great likelihood that the need could be underestimated if the Division only captured the number of patients, conversely if the need methodology considers only the number of procedures, there could be an overestimation of the need for services. In the numerical need, patients are forecast for the horizon year by using current year rate population data projected forward for five years. A net surplus or deficit of rooms is determined by subtracting the total ambulatory surgery operating rooms needed from the inventory of ambulatory surgery services operating rooms in the planning area. The inventory is determined by using annual survey data. Prior to the approval of a new or expanded ambulatory surgery service, the aggregate utilization of all existing and approved ambulatory surgery services in the planning area should equal or exceed 80% during the most recent year.

Ms. Hepburn noted that the numerical need calculation relies on the submission of surveys for the official inventory. The Department recognizes that this data reporting process is not ideal since the information on the survey can be changed at-will throughout the survey process. She further noted that the current planning area for ambulatory surgery services encapsulates 13 health-planning areas. She said that the

planning area maps for several other regulated services were recently changed from health planning areas to the state's service delivery regions. She indicated that the committee, during discussions about planning areas, might want to further explore whether the planning area maps should align with other CON services, which now use State Service Delivery Regions.

EXCEPTION TO NEED: The Department allows an exception to the need to remedy an atypical barrier to ambulatory surgical services based on cost, quality, financial access or geographic accessibility. The applicant has the burden to prove that these access issues exist and can be remedied by their service provision.

CONTINUITY OF CARE: The current plan documents the need for hospital affiliation agreements and patient transfer agreements and written policies and procedures for discharge planning.

QUALITY OF CARE: The current plan has requirements that ensure a credentialing process; an appropriate level of trained personnel and a patient care review process.

COST: The existing plan documents the need for a utilization review process and ensures that the applicant has a plan in place to ensure that charges are reasonable when compared to other similar surgery services serving the same planning area.

LICENSURE/JCAHO: The plan requires that the applicant provide a statement of the intent to meet appropriate accreditation requirements (JCAHO or other accrediting bodies).

FINANCIAL ACCESS: Applicant is required to demonstrate access to services regardless of patient's ability to pay, payment source and must provide care to indigent or charity patients which meet or exceed 3% of annual gross revenues.

TAC members asked about the Department's ability to enforce indigent care commitments that are stipulated in the plan and rules. Ms. Hepburn indicated that the Department could recoup funds from providers who do not provide the indicated level of commitment.

Ms. Hepburn also indicated that the Department would like the TAC's guidance with specific regard to the following:

- What operating rooms should be counted and how they should be counted?
- Should the Division continue to count patients or should we revert to procedures?
- What planning areas should be used? (13 Health Planning Areas (HPAs) or 12 State Service Delivery Regions (SSDRs)?

IDENTIFICATION OF PLANNING PRINCIPLES AND GOALS FOR A GEORGIA PLAN

TAC members developed the following list of items that they felt the committee should address during its deliberations. This list is not exhaustive and can be expanded throughout the TAC's planning process.

- Exception to Need Language (cost, quality, financial and geographic access)
- Committee should define "single specialty" and develop a list of core specialties
- Financial Accessibility including Indigent and Charity Care Commitments
- Define operating rooms and what rooms should be counted (look at Medicare rules and regulations)
- Determine whether to use "patients" or "procedures" in need determinations (look to Medicare definition)
- Continuity of Care
- Quality of Care
- Determine use of planning areas versus state service delivery regions
- Define limited purpose
- Community focus
- Relocation/Replacement issues

IDENTIFICATION OF DATA AND ADDITIONAL INFORMATION

The committee requested the following data and information:

- List of specialties/subspecialties and the range of related procedures that can be performed by such clinicians
- Physician-owned limited service facilities that trigger CON capital threshold (how many currently exist)
- Other state information (that address the identified principles)
- Identify the types of procedures that are being done in ambulatory surgery centers and the types of physicians that are performing the procedures. Kevin Chilvers offered to share some sample data from the HCA system.
- Determine what data the Department of Human Resources/Office of Regulatory Services has

Ms. Hepburn indicated that the committee is targeting completion of its work prior to the Health Strategies Council's (council) meeting that is scheduled for November 2003. The rules and corresponding component plan would be presented to the Council at that time. Upon their approval, the Council will forward the rules to the Board of Community Health for posting and public comment.

SCHEDULE FOR UPCOMING MEETING

The next meeting of the Ambulatory Surgical Services TAC is scheduled for Tuesday, June 24, 1:30 pm – 3:30 pm at 2 Peachtree Street, 34th Floor conference room.

PUBLIC COMMENTS

Noone had signed up to speak. Dr. Baker recognized Everette Jenkins of Strategic Health Concepts who addressed the TAC. Mr. Jenkins has submitted a letter for distribution to TAC members. The letter will be included with the data and information materials that will be forwarded to the TAC prior to the next scheduled meeting.

There being no further business, the meeting adjourned at 3:30 pm.

Minutes taken on behalf of Chair by Stephanie Taylor and Valerie Hepburn.

Respectfully Submitted,

William G “Buck” Baker, Jr., MD, Chair